LEGAL RIGHTS • HUMAN DIGNITY

AND

THE

MINNESOTA

STORY

LEGAL RIGHTS, HUMAN DIGNITY AND ADVOCACY: THE MINNESOTA STORY

Minnesota has a full time advocate in each of the mental hospitals which operate under the Department of Public Welfare. A search of the literature indicates that Minnesota may have been the first state in the country to make this kind of commitment to the concept of advocacy. The purpose of this booklet is, therefore, to inform readers about the advocacy system in Minnesota and to give a historical perspective concerning the development of the advocacy concept in the state.

Before the 1950's, the Minnesota state hospital system was not unlike most of those throughout the country; it was probably no better or no worse. Large, overcrowded, under-staffed, under-funded, and custodial oriented facilities were commonplace. Over 15,000 people diagnosed as mentally ill, mentally retarded, or chemically dependent resided in Minnesota state hospitals and there were few programs designed to serve special treatment needs. Under such conditions, the hospitals tended to be impersonal and dehumanizing and there were few, if any, provisions for protecting the legal rights and human dignity of the consumers of our psychiatric services.

1947 proved to be a significant year for mental health in Minnesota. This was the year that Governor Luther Youngdahl appointed the Governor's Advisory Council on Mental Health to study the mental health delivery system and its problems. The council drew up a list of recommendations which were presented to the Governor and to the state legislature resulting in the passage of the Mental Health Policy Act by the legislature; this act set environmental standards, goals and objectives and generally spelled out new attitudes and augmented services in the mental health system in the state.

The period of 1949 through 1951 saw a quickening interest in providing outpatient follow up clinics. The first such clinic was established at Fergus Falls and several others followed in the early 50's. There are now twenty-five mental health centers serving the citizens of the state.

In 1951, the legislature merged the Division of Social Services with the Division of Public Institutions thereby creating the Department of Public Welfare. During this period, the concept of follow up services really came into being, aided by two specific legislative amendments which provided that local county welfare boards would provide follow up services and also, that they would investigate all petitions for commitment in behalf of the court.

In 1952, a Volunteer Services network was established in all state hospitals and at the departmental level this was apparently the first such service in the country established by a state welfare department. As a result, volunteering individuals and groups began to respond more systematically to the human needs of patients and to provide a meaningful tie to the "outside" world.

The period encompassing 1953-1957 saw the developing trend for the use of psychotropic drugs, the decline in the use of electro-convulsive therapy, the elimination of insulin shock therapy, and an increase in the number of people being discharged from state hospitals. At that time an enabling act was passed by the legislature to establish community mental health centers through 50-50 matching grants. This was, in effect, a movement toward community-based programs and the beginning of the application of the "least restrictive alternative." As community-based mental health centers opened to serve the entire state, the hospital out-patient clinics were ultimately closed.

1951 saw the appointment of Dr. Ralph Rosen to the position that could be considered as Minnesota's first commissioner of mental health. That was followed in 1954 by the appointment of Dr. Dale Cameron as the medical director for the Medical Services Division of the Department of Public Welfare.

During 1955-1959, the trend to more open hospitals was in full swing, as community mental health centers and county welfare departments became more involved in the lives of patients and former patients. Patients' Councils were established in each of the state hospitals, providing a forum for consumers to express complaints and to make suggestions. These councils, which usually met monthly, forwarded their complaints and recommendations to the local Medical Director for consideration and resolution.

Dr. David J. Vail, who was appointed Director of Medical Services for the Department of Public Welfare in 1959, became a champion of open hospitals and improved humane treatment. Standards of care were improved, and by 1960 all state hospitals were fully accredited by the Joint Commission on Accreditation. In 1963, Dr. Vail called together an Institutional Assembly which addressed the problems of dehumanization in state facilities. In the same year, the Humane Practices Committee (the forerunner of the present advocacy system) was established at both the state and local levels. The Ward Living Conditions Survey (later versions were called the "Residential Environment Survey") was developed in 1965 and this instrument measured both current need and year by year improvements in each ward of each state hospital.

1967 saw passage and implementation of the Minnesota Hospitalization and Commitment Act, which completely overhauled and replaced the old legislation

and offered, for the first time, real and meaningful due process protection for proposed patients who heretofore could be committed with relative ease. The Minnesota Review Boards were established under the same act. Each hospital is served by a Review Board appointed by the Commissioner of Welfare; each Board is comprised of a psychologist, psychiatrist or knowledgeable physician, an attorney, and a lay person, none of whom may be employed by the Department of Public Welfare or its agencies. These Boards meet on a regularly scheduled basis at each hospital to hear resident complaints about admission, treatment and retention, and to make recommendations to the Commissioner for action or resolution when this is indicated. There is also a Special Review Board for the state to hear cases of those individuals who have been committed as Mentally Ill and Dangerous.

In 1967 the American Psychiatric Association presented its Bronze Award to the Department for its all-out attack on dehumanization.

A Public Operations Office was established at the Department of Public Welfare in 1970 through a federal grant This office was staffed by three persons who worked actively in behalf of individuals who were hospitalized in our state hospitals. While those persons were never actually labeled as advocates, this is primarily what their function was, and it provided consumers of psychiatric services a method to have their grievances heard in a way which was both immediate and responsive. This office also worked for policy changes and responded to the problems and concerns of the local Human Practices officers in the state hospitals.

1971 proved to be a very sad year for the Department of Public Welfare and for the State of Minnesota. This was the year of Dr. Vail's untimely death, and it was a loss from which it has been difficult to recover even though the vestiges of

Dr. Vail's commitment to stamp out dehumanization lived on.

From 1964 to 1971, Humane Practices Institutes were held annually to bring together hospital administrators, treatment personnel, local Humane Practices officers, Department of Public Welfare officials and representatives of outside groups such as the Mental Health Association, Association for Retarded Citizens and the Welfare Directors Association. In these Institutes decision-makers and interested participants (professional and non-professional) addressed the problems of dehumanization, program and environmental needs, staff-resident relationships, etc. The Institutes also reviewed accomplishments, addressed immediate problems, and set future goals and directions. The idea of Humane Practices and the yearly Institutes passed from the scene as some decision-makers felt other activities made them unnecessary. However, not everyone agreed, and during the last years of the Institute (1970-71), the pressure began to mount for the establishment of a specific advocacy system in state institutions. Consequently, the first advocate in the state hospital system was appointed on August 1, 1972 at Fergus Falls State Hospital. With the active support and leadership of Assistant Commissioner Wes Restad, other hospitals followed and by 1974 an advocacy function was operational in each state hospital. The Veterans Administration Hospital at St. Cloud soon joined the movement and appointed a full time advocate.

In mid-1972, a committee was appointed by the Medical Services Division to work on policies and procedures for the advocacy function in the system. Among the difficulties experienced by the committee was the question of whether an ombudsman (impartial fact-finder) or an advocacy (adversary) system would be the most appropriate. After much debate, the advocacy approach was selected

and the policy written. It first appeared in the department's Administrative Manual on May 18, 1972; a copy of the most recent revision (August 20, 1978) is appended. This policy formally launched an advocacy system in Minnesota. The advocates in the state hospital system operate with broad authority, which includes:

1. Access to all treatment areas, resident treatment plans, programs, and records;
2. Access to all available human and material resources to carry out the advocacy function;
3. Authority to take a case which cannot be resolved directly to the Chief Executive Officer;
4. If not resolved at the local level, the authority to refer cases to appropriate resources outside the facility.

In practice, the advocates have been able to move freely throughout the facility, have been able to offer their services directly to the client, and submit their observations concerning programs and living conditions directly to the responsible program director and the Chief Executive Officer. It has also provided an additional channel for treatment staff to bring their concerns about conditions of care and treatment to the attention of administration. Most of the advocates are members of the hospital management group and can, therefore, represent the resident's point of view at this level.

The advocates consult with residents in the areas of: a) legal status; b) legal rights; c) treatment plans, including length of hospitalization; d) facility, unit, and ward policies as they affect residents; e) living conditions; f) resident-staff relationships; and g) criminal and civil matters and welfare policies outside the jurisdiction of the involved facility.

The advocates themselves make up a rather diverse group and include both professionals and non-professionals. Their efforts to date have generally been only loosely coordinated at the departmental level and their operating methods have to varying degrees been influenced by personal style and their own interpretation of local conditions and management. However, the present Commissioner, Edward J. Dirkswager Jr., and the Assistant Commissioner for Mental Health, Harvey Caldwell, have recently created a three-person office to assist and coordinate the efforts of the local advocates. This office will also interpret departmental policies to the local level and, if needed, provide case follow up at the departmental level. The function is known as the Client Protection Office.

Since the advocacy system's inception, advocates have been involved in approximately 12,000 individual cases within the state hospitals. In a typical multi-purpose campus (those serving the mentally ill, mentally retarded, and chemically dependent) an advocate averages about 75 cases a month or approximately 800 cases a year. Those advocates who serve facilities for only the retarded, tend to average less than that, probably because of the difficulties of this group to adequately verbalize its concerns. A significant percentage of the cases (somewhat over one-half) involve rights under the Minnesota Hospitalization and Commitment Act or questions of treatment or retention. Almost as many cases are concerned with staff-resident relationships and complaints concerning the hospital environment.

The preceding might give the impression that advocacy" was easily conceived and implemented in Minnesota. This was not, in fact, the case. As has been true elsewhere, resistance to the concept occurred during its development and remains to some degree in some quarters. While the concept of advocacy is

rather universally embraced within the state hospital system, it is less evident in some other segments of the delivery system. There are, so far, only a few advocates operating within the county welfare department and there are few, if any, advocates in place among the mental health centers and private treatment facilities. It: would therefore appear that the Department of Public Welfare, through its Division of Mental Health, is at present the main supporter of the advocacy concept. Although the advocates are sometimes seen as interfering with the treatment efforts of the team, it must be said that the advocacy system generally has the active understanding and support of treatment personnel and decision-makers in the department.

The advocates have been supported in their efforts by recently passed legislation (1976) which defines a Client Bill of Rights and also spells out a Grievance Procedure (M.S. 144.651) which is appended.

Minnesota can look at its advocacy efforts with some pride. From a rather rocky beginning, advocacy now finds itself operating from a firm foundation. With the continuing support of the leadership of the Department and the leadership of individual state hospitals, we are confident the State will continue to provide consumers of psychiatric services a method of appeal that is recognizable, immediately responsive, and effective.

ADDENDUM

Advocacy Policy

INTRODUCTION

The purpose of the public welfare system in Minnesota is to help individuals and families deal with their problems by providing the following types of assistance:

1. financial assistance;
2. social services;
3. educational, medical and related services;
4. rehabilitation of the blind and visually handicapped;
5. care and treatment for mentally ill, mentally retarded and other developmentally disabled persons;
6. services for the aged, deaf and hard of hearing; and
7. services for persons with problems of chemical dependency.

This assistance is offered in a manner that preserves the dignity, as well as human, civil, and legal rights of the individual and families. The Department recognizes the fact that in an organization as large as the Department of Public Welfare, variations from the above purpose, as expressed in individual case decisions, can occur in practice. It is also recognized that policies and procedures affecting individuals and families can become obsolete or otherwise unresponsive to the point that they do not fulfill their original intent. It is the Department's objective, through procedures to be developed by operating units of the Department upon the basis of this policy, to ensure that there are means for identifying and correcting problems within the Department. All persons within the Department should be aware of alternative means (e.g. appeals, grievances, etc.) available to ensure that rights and humane practices are in fact guaranteed.

POLICY ON ADVOCACY

The Department hereby authorizes development and implementation of advocacy procedures by departmental units and operating agencies for consumers of human services that will ensure that legal, civil, and human rights will be upheld in a way that is recognizable and immediately responsive to grievances of individuals and families and will, at the same time, provide an approach for modifying the decision-making process.

It is also Department of Public Welfare policy on advocacy that all employees of the public welfare system, welfare boards, human service boards, area boards, institutions, and persons providing services paid from public welfare funds are responsible for helping to protect the individual's and families' (consumer's) human, civil, and legal rights to apply for, as well as receive, if eligible, financial assistance, social services, and medical, educational, and related care and treatment. PURPOSE OF ADVOCACY POLICY

It is the intent of this policy to assure that:

1. People who are applicants and recipients are made knowledgeable about their rights to financial assistance, social services, care, treatment, medical services, and educational services, and are given humane and civil consideration by all employees and other involved persons within the public welfare system.
2. There are means, including advocacy procedures based upon and authorized by this policy, established by the operational units of the Department, for acting on suspected violations of consumer rights and for correcting laws, rules, policies, and practices that are in-

violation of consumer rights.

3. Individuals and groups of clientele, as well as public welfare system employees and other persons within the department covered by this policy, are protected from harassment if they call attention to suspected violations of rights.
4. With the written permission of the consumer and appropriate identifica tion of the nature of the role being assumed, it is expected that employee may be consumer advocates and plead for, act on behalf of, speak for, a otherwise assist the cause of consumers of financial assistance, social services, care and treatment, and related services.
5. There is recognition that consumers of the public welfare system's services may want as advocates people other than employees (or other involved persons) within that system.
6. Effective implementation of the advocacy policy requires that persons working within the public welfare system work together in a cooperative fashion to define an operational framework for advocacy procedures.
7. Advocacy activity is viewed as appropriate in all organizational units, including those that have separated aids from services in accordance with Departmental policy, and is seen as a positive and appropriate stage in the development of the human services system.
8. The advocacy policy is viewed as a policy approach that enables and facilitates internal resolution of problems within the statewide public welfare system.

GRIEVANCE PROCEDURE

This is a mechanism to consider and resolve a dispute or disagreement raised by a client.

1. M.S. 144.651 provides that grievances may be lodged for violations relating to the "Bill of Rights".
2. You may want to appeal decisions made by others regarding your treatment while here.
3. You should feel free to raise questions and concerns about anything having to do with your hospitalization.

Grievances will be responded to as soon as possible. At the time you make your grievance known you will be told when to expect a response and from whom.

You may submit (verbally or in writing) your grievance to the person or agency of your choice.

There are many resources available to help you to initiate your grievance. Some of them are:

1. Your treatment team.
2. Chief Executive Officer.
3. Client Advocate.
4. Review Board.
5. Minnesota Office of Health Facility Complaints. The Client Advocate is available to assist you in submitting or resolving your grievance and can inform you of other available resources.

Edward J. Dirks wager Jr., Commissioner, Department of Public Welfare
Centennial Building, St. Paul, Mn. 55105 612-296-2701

Harvey Caldwell, Assistant Commissioner, Mental Health Bureau, DPW
Centennial Building, St. Paul, Mn. 55105 612-296-2791

Client Protection Office, Department of Public Welfare
Centennial Building, St. Paul, Mn. 55105 612-296-5690

ADVOCATES:

- Anoka State Hospital	Anoka, Mn. 55303	612-421-3940
- Ah-Gwah-Ching Nursing Home	Walker, Mn. 56430	218-547-1250
- Brainerd State Hospital	Box 349, Brainerd, Mn. 56401	218-828-2201
- Cambridge State Hospital	Cambridge, Mn. 55008	612-689-2121
- Faribault State School and Hospital	Faribault, Mn. 55021	507-334-6411
- Fergus Falls State Hospital	Box 157, Fergus Falls, Mn. 56537	218-739-2233
- Moose Lake State Hospital	Box B, Moose Lake, Mn. 55767	218-485-4411
- Rochester State Hospital	2110 E. Center St.,Rochester Mn., 55901	507-285-7002
- St. Peter State Hospital	100 Freeman Dr.,St. Peter, Mn., 56082	507-931-3000
- Willmar State Hospital	Box 1128, Willmar, Mn. 56201	612-235-3322
- Veterans Administration Hospital	St. Cloud Gov. Site St. Cloud, Mn. 55403	612-252-1670

Written By: Bill Johnson
Mary Olympia
Prepared By: Marlene Messenger
Edited By: Roland Peek, Ph.D.
Cover Design By: Robert P. Johnson